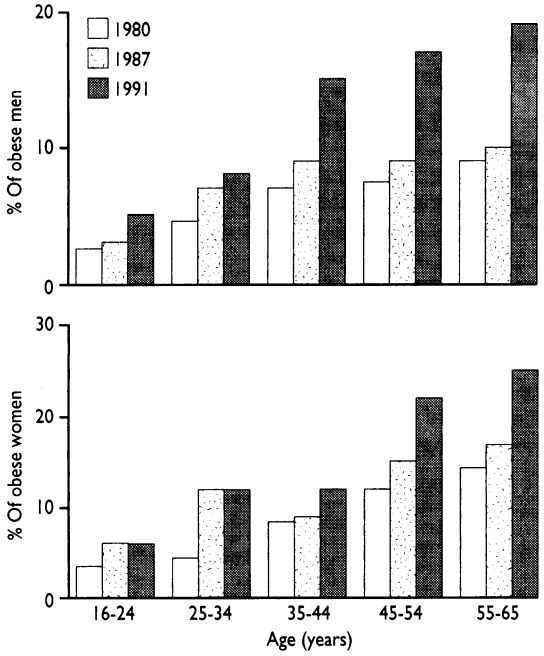


Prevalence of obesity (body mass >30 kg/m²) in a representative sample of British population in 1980, 1987, and 1991[5]

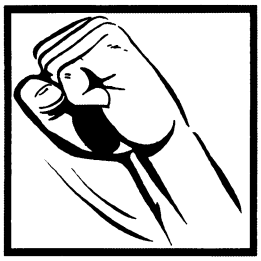
approach is required. Firstly, the Health Education Authority should publicise the level at which being overweight becomes a medical (rather than a cosmetic) problem: this occurs at a Quetelet's index of somewhere between 25 and 30. Secondly, non-profit making but self financing slimming groups, led by state registered dietitians, should be set up as part of the health education service for overweight people. Such groups have been shown to be practicable and effective for the past 15 years in the Harrow health district.[6] Thirdly, the group leader should be able to refer members of the group who present special problems to a hospital specialist for further investigation, advice, or treatment.

I have been running a hospital obesity clinic for more than 20 years: it operates inefficiently because most of the patients have not previously had proper dietary advice. If they had been filtered through a well run slimming group many would not have needed to come, and (for those who needed referral) time would have been saved by not having to start from scratch with dietary management. The objective is to lose 0·5-1·0 kg/week by a combination of restricted energy intake (dieting) and increased energy output (exercise) and to maintain the reduced weight indefinitely. Methods by which this may be achieved are discussed elsewhere.[7] Obesity is often treated badly. The solution is not to pretend it does not matter but to treat it well.

1 Garrow JS. *Obesity and related diseases.* London: Churchill Livingstone, 1988.
2 Garner DM, Wooley SC. Confronting the failure of behavioral and dietary treatments for obesity. *Clin Psychol Rev* 1991;**11**:729-80.
3 Bortz WM. A 500 pound weight loss. *Am J Med* 1969;47:325-31.
4 Garrow JS, Webster JD. Effects on weight and metabolic rate of obese women of a 3·4 MJ (800 kcal) diet. *Lancet* 1989;i:1429-31.
5 White A, Nicolaas G, Foster K, Browne F, Carey S. *Health survey for England 1991.* London: Office of Population Censuses and Surveys, 1993.
6 Bush A, Webster J, Chalmers G, Pearson M, Penfold P, Brereton P, *et al.* The Harrow slimming club: report on 1090 enrolments in 50 courses, 1977-1986. *Journal of Human Nutrition and Dietetics* 1988;1:429-36.
7 Garrow JS. Obesity. In: Garrow JS, James WPT, eds. *Human nutrition and dietetics.* 9th ed. Edinburgh. Churchill Livingstone, 1993:465-79.

Dietary treatments for obesity are ineffective

Susan C Wooley, David M Garner



University of Cincinnati, College of Medicine, Cincinnati, Ohio 45267, USA
Susan C Wooley, *professor of psychology*

Beck Institute for Cognitive Therapy and Research, Bala Cynwood, Pennsylvania 19001, USA
David M Garner, *director of research*

Correspondence to:
Dr Wooley.

It is surprising that debate continues about the effectiveness of dietary treatments for obesity. Perhaps this is partly related to ambiguity in the term effectiveness. It is well known that most treatments produce temporary weight loss. But it is equally well known that 90% to 95% of those who lose weight regain it within several years.[1] This poor outcome has led to charges that traditional treatments for obesity should be abandoned and countercharges that it is irresponsible to withhold treatment for such a serious problem. The failure of reducing diets to produce lasting improvement was recently reiterated at a National Institutes of Health consensus conference, which also warned about the adverse effects of treatment.[2]

The failure of fat people to achieve a goal they seem to want—and to want almost above all else—must now be admitted for what it is: a failure not of those people but of the methods of treatment that are used. It is no longer a mystery why diets have such a poor long term record of success. Indeed the failure of obese people to become or remain thin by "normalising" their food intake follows logically from studies on the heritability of obesity,[3] the biology of weight regulation,[4] and the physiology of energy metabolism.[5]

Demand for treatment is not a justification

Yet many remain enthusiastic about treatment. It could be said that the main evidence for the value of dieting is that health professionals continue to prescribe it. Inertia feeds on itself, failure to change coming to serve as a silent argument that no change is needed. However, this only partially accounts for the resistance to change among those treating obesity. Recent findings regarding the benefits of antibiotics in treating ulcers and the comparative outcomes of procedures for emergency cardiac care have been rapidly translated into medical practice. In these cases doctors have only had to adjust what they do; in the case of obesity treatment, however, there is no replacement procedure. The question is whether to abandon treatment, putting many specialists out of business, in the face of relentless popular demand. Desperate consumers are willing to bear the burden of responsibility for failure in exchange for continuing access to treatment. This desperation is best illustrated by Ravitch and Brolin's observation that patients who had had obesity surgery were unwilling to consider reversal even when it was discussed in terms of saving their lives.[6]

As if to avert the central question by introducing more variables, the debate has shifted from the universal mandate for one treatment, to the matching of available treatments (from self directed programmes to surgery) to individual, depending on level of obesity and factors such as diet history.[7] Notably, even for patients as little as 5% overweight the option of withholding weight loss treatment does not appear on the decision tree. Wadden has argued that the "no treatment" option "cannot be universally endorsed until there are definitive research data."[8] This is an unusual twist in medical science: demanding proof of effectiveness of no treatment rather than of active intervention. Although the no treatment stance has been viewed as radical, it is actually quite conservative. The drug industry has to show both safety and efficacy

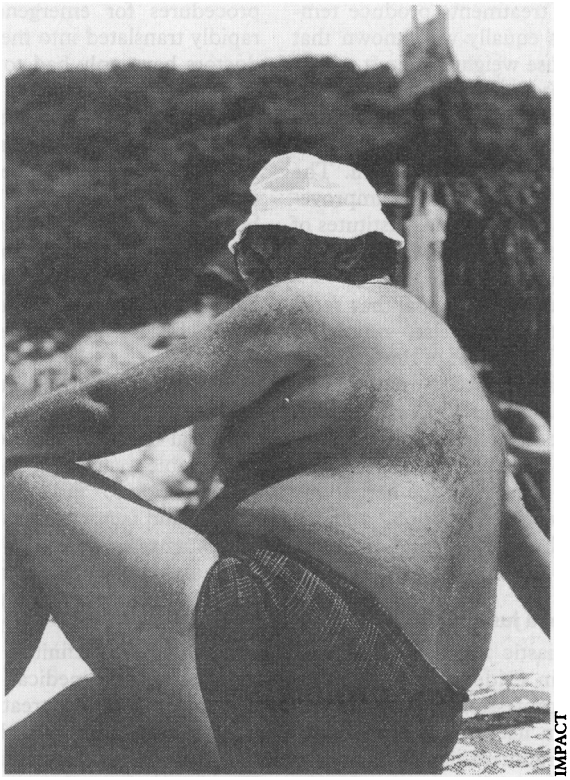
Commentary: Leave obesity alone in healthy and happy patients

Some years ago my colleagues and I attempted to reduce obesity in patients attending a cardiovascular risk clinic. After a concerted programme of education and advice with the full participation of dietitians our four year follow up showed that we had no impact at all. Reducing weight in the controlled surroundings of a metabolic ward is one thing, doing so in the real world is something else. From the standpoint of reducing cardiovascular risk, weight reduction is attractive, and although the process described by Professor Garrow is important, I have doubts about whether it is widely and easily applicable. If a person's overall cardiovascular risk profile is good and they have no self esteem problem with their obesity then it is probably best to leave well alone.—PETER C RUBIN, *professor of therapeutics, University of Nottingham*

before commercial approval of its products, and, in general, the burden of proof lies with those advocating treatment.

Health effects of dieting

Proponents of dietary treatment point to the health risks of obesity. Amassing evidence that weight loss would be beneficial does not make treatment any more effective. Therapies with modest success rates are defensibly used when the prognosis for an untreated person is poor and treatment poses no additional risks. But in the case of dietary treatments for obesity neither of these assumptions is clearly met. Success rates are not even modest, and the health risks associated with untreated obesity remain controversial, largely because in societies in which dieting is common the effects of high weight are confounded with the effects of weight cycling.[1 9] Dieting not only fails the criterion of being without risk but has been implicated in increased morbidity and mortality in several large studies.[1 9 10] Dieting often has negative effects on psychosocial functioning and can lead to eating disorders such as the binge eating disorder and even bulimia nervosa.[11] Finally, dietary treatments are costly, unpleasant, and, when they fail, tend to damage self esteem.



IMPACT

Happy to be fat?

Treat the patient not obesity

Of course obese patients should be treated for illnesses and injuries like everyone else. They should be counselled to eat a healthy balanced diet and to get appropriate amounts of exercise. They should be treated for the emotional disorders they have and not, as is so often the case, ones they do not have. They should be treated for eating disorders such as binge eating, if they have them. Some must be helped to stop chronic overeating caused by despair over repeated failure. Some will need help in establishing "normal" eating patterns after decades of diets and diet rebound. They should be helped to deal with the social and emotional implications of remaining fat and to improve their body image. One of the highest priorities should be to protect them from blame for their condition and the enormous costs resulting from fat prejudice.

Gotmaker *et al* recently put the costs of prejudice in terms that everyone can understand: $6710 (£4470) a year in lost earnings, as well as fewer years of education and a reduced chance of marriage for American women in the top 5% of weight for height.[12] Many previous studies have documented discrimination in admission to colleges, employment, promotion, access to housing, and attribution of personality traits.[11 13] In a commentary Stunkard and Sorensen criticised the medical profession for being "among the chief offenders" in the perpetuation of prejudice and issued a "call to action against the stigmatisation of obesity."[14]

But how? Prejudice is revived daily in the routine interactions of doctor and patient in which patients are offered dietary treatments and fail to benefit from them. This ongoing failure demands a culprit: either the treatment is flawed or the patient is flawed, failing to comply with the appropriate remedy. As the more credible medical profession is refusing to blame its prescriptions patients are left to absorb the stigma of failure.

We should stop offering ineffective treatments aimed at weight loss. Researchers who think they have invented a better mousetrap should test it in controlled research before setting out their bait for the entire population. Only by admitting that our treatments do not work—and showing that we mean it by refraining from offering them—can we begin to undo a century of recruiting fat people for failure.

1 Garner DM, Wooley SC. Confronting the failure of behavioral and dietary treatments of obesity. *Clinical Psychology Review* 1991;6:58-137.
2 National Institutes of Health. Methods for voluntary weight loss and control. *National Institutes of Health Technology conference statement.* Bethesda, Maryland: National Library of Medicine, Office of Medical Applications of Research, 1992.
3 Meyer JM, Stunkard AJ. Genetics and human obesity. In: Stunkard AJ, Wadden TA, eds. *Obesity theory and therapy.* 2nd ed. New York: Raven Press, 1993:137-49.
4 Keesey RE. Physiological regulation of body energy: implications for obesity. In: Stunkard AJ, Wadden TA, eds. *Obesity theory and therapy.* 2nd ed. New York: Raven Press, 1993:77-96.
5 Ravussin ER, Swinburn BA. Energy metabolism. In: Stunkard AJ, Wadden TA, eds. *Obesity theory and therapy.* 2nd ed. New York: Raven Press, 1993:97-123.
6 Ravitch MM, Brolin RE. The price of weight loss by jejunoileal shunt. *Ann Surg* 1979;190:382-91.
7 Brownell KD, Wadden TA. The heterogeneity of obesity: fitting treatment to individuals. *Behavior Therapy* 1991;22:153-77.
8 Wadden TA. The treatment of obesity: an overview. In: Stunkard AJ, Wadden TA, eds. *Obesity theory and therapy.* 2nd ed. New York: Raven Press, 1993:197-217.
9 Ernsberger P, Haskew P. Health implications of obesity: an alternative view. *Journal of Obesity and Weight Regulation* 1987;6:58-137.
10 Andres R, Muller DC, Sorkin JD. Long-term effects of change in body weight on all-cause mortality. *Ann Intern Med* 1993;19:737-43.
11 Wadden AT, Stunkard AJ. Psychosocial consequences of obesity and dieting: research and clinical findings. In: Stunkard AJ, Wadden TA, eds. *Obesity theory and therapy.* 2nd ed. New York: Raven Press, 1993:163-77.
12 Gortmaker SL, Must A, Perrin JM, Sobel AM, Dietz WH. Social and economic consequences of overweight in adolescence and young adulthood. *N Engl J Med* 1993;329:1008-12.
13 Rothblum E. I'll die for the revolution but don't ask me not to diet: feminism and the continuing stigmatization of obesity. In: Fallon P, Katzman M, Wooley S, eds. *Feminist perspectives on eating disorders.* New York: Guildford Press, 1994:53-76.
14 Stunkard AJ, Sorensen TIA. Obesity and socioeconomic status—a complex relation. *N Engl J Med* 1993;329:1036-7.